STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085022	A. BUILDING _____ B. WING _____	C 07/07/2011

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EMILY P. BISSELL HOSPITAL	3000 NEWPORT GAP PIKE WILMINGTON, DE 19808

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from June 27, 2011 through July 7, 2011. The deficiencies contained in this report are based on observations, interviews, review of clinical records as well as other documentation as indicated. The facility census on the first day of the survey was seventy eight (78). The stage 2 survey sample totaled 32.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, review of the clinical record and interview, it was determined that the facility failed to have 1 (R59) out of 32 sampled stage 2 residents free from physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptom. The facility assessed R59 for side rails as not indicated, yet bilateral 1/2 side rails were used for this resident. Findings include: R59 was admitted to the facility on 4/6/11. A Side Rail Assessment, completed on 4/6/11, stated that side rails did not appear to be indicated at this time. The admission Minimum Data Set assessment	**Immediate Corrective Action** F 221 **Identifying other residents having the potential to be affected**	Emily P. Bissell Hospital strives to provide quality services for each resident to attain and maintain his /her highest practicable well-being in an environment that prohibits the use of restraints for discipline or staff convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Although resident # 59 was care planned as not needing side rails, staff inadvertently pulled up the side rails after performing care. A side rail assessment was completed on 07/11/11 for resident # 59, and it was determined that resident did not have medical symptoms that warrant the use of restraints. Resident R #59's bed rails were removed. All residents with side rail restraints are at risk for this deficient practice. The facility will identify all residents with side rails and will complete a comprehensive assessment to identify the medical condition / symptoms for which a restraint is being considered. The assessment will include attempts to use a less restrictive device.	7/11/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Director 8/6/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 (MDS), dated 4/25/11, stated that R59 had no restraints or bed rails. On 6/27/11 at 2:45 PM, R59 was observed in bed with bilateral 1/2 side rails up. On 7/1/11 at 5:35 PM, R59's bed was observed with the door side rail up and the window side rail down. R59 was in the dining room for dinner. E16 (RN charge nurse) was interviewed on 7/1/11 about 5:45 PM. E16 confirmed that side rails were not in R59's care plan nor were they on the CNA (certified nurses aides) flow sheets. E16 stated that she thought putting the side rails up was an oversight by the CNA's. Findings were discussed with E3 (Director of Nursing) on 7/1/11 at 6 PM. E3 confirmed that side rails were not on the admission MDS or the care plan and R59 should not have had side rails. On 7/1/11 at 6:07 PM, E3 asked E32 (CNA) if the resident puts up her own side rails and she stated no, that the CNA's put them up for R59 sometimes. The facility assessed that side rails were not indicated for R59, yet she was observed in bed with bilateral 1/2 side rail's being used.	F 221	**Systemic Response** All residents with side rail restraints will be reviewed monthly to determine continued need of a restraint and update care plan as needed. **Monitoring** All residents with side rail restraints will be reviewed at their quarterly IDCC meeting to assure the restrictive device will be used only in circumstances whereby the resident's medical symptoms or to aid the resident with mobility /activity and that an individualized plan of care has been completed for the use of a restraint. Results will be reviewed at the Quality QA meeting.	8/05/11 and ongoing 8/19/11 and ongoing
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced	F 241		

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F 241	Continued From page 2 by: Based on observation and interview, the facility failed to promote care for residents in a manner and in an environment that maintained each resident's dignity and respect in full recognition of his or her individuality for 6 residents (R2, R27, R42, R44, R49, R78) during the lunch dining observation on 6/27/11. For four of the residents in the third floor dining room, staff gloved to feed the residents. For one resident (R27) his lunch tray was on his bedside table along with his dirty bath water in a basin. During the lunch observation on 6/27/11 and during a surveyor interview, observations were made of several staff who failed to knock on doors and/or wait for permission to enter prior to entering residents' rooms. Findings include: 1. The 3rd floor dining room observation of the lunch meal on 6/27/11 revealed the following: a. E10 (CNA) gloved and proceeded to feed R44; b. E5 (Nursing Supervisor) gloved and proceeded to feed R2; c. E11 (CNA) gloved and proceeded to feed R78; d. E12 (CNA) gloved and proceeded to feed R49. The facility failed to promote a dining environment that maintained resident's dignity. On 6/27/11 at 2:20 PM in an interview with E10, he stated that he and the staff always use an alcohol type solution to clean their hands in the dining room and then glove before feeding residents. 2. On 6/27/11, multiple staff were observed entering resident rooms on the second and third floors with lunch trays without knocking or announcing themselves prior to entering rooms. The following were observed:	F 241		
		Immediate Corrective Action	Item # 1 Immediate corrective action was taken to remind staff that gloves are not to be worn while feeding resident.	7/11/11
			Item # 2a and 2b Staff received reminders to respect the residents' right to privacy regarding knocking on residents' doors and waiting for a response before entering resident rooms.	7/11/11
			Item # 3 Upon notification of incident, E #30 received counseling regarding basin left on bedside table with dirty bath water and placing resident food tray on the same table next to the dirty water, discarded dirty water and fed resident.	6/27/11
			Item # 4a E#13 received reminders to respect residents' right to privacy regarding knocking on residents' doors and waiting for response before entering resident rooms.	7/11/11
			Item # 4b E#10 and E#15 both received reminders to respect residents' right to privacy regarding knocking on residents' doors and waiting for response before entering resident rooms.	7/11/11
		Identifying other residents having the potential to be affected	All residents have the potential to be affected by these deficient practices.	

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F 241	Continued From page 3	F 241		
	a. On the second floor at 11:45 AM, E17 (CNA) entered rooms 201, 202 and 203. E33 (CNA) entered room 206. At 11:49 AM E17 returned to room 203 and he entered rooms 211 (11:51 AM) and 213 (11:52 AM) without knocking, announcing himself and waiting for permission to enter the rooms. b. On the third floor at 12:12 PM E7 (LPN) entered room 317, E28 (RN) entered room 323 and E14 (CNA) entered room 316 without knocking or announcing themselves prior to entering the rooms.	**Systemic Response**	Item # 1 The Infection Control Policy on Food Handling was updated on 08/02/11, to clarify infection control practice while maintaining residents' dignity while feeding the resident (see Attachment A) Training will be provided by staff development and Infection Control Nurse to all nursing staff regarding maintaining resident dignity and policy update on Infection control-food handling during dining, (proper hand hygiene, gloving).	8/19/11
	3. On 6/27/11 at 11:55 AM, R27 was observed sitting up on the side of his bed with his bedside table in front of him. R27's lunch tray was sideways on the bedside table and a basin with the resident's used bath water was beside the lunch tray.		Items # 2a, 2b, 4a & 4b Training will be provided by staff development and Infection Control Nurse to all nursing staff regarding knocking on resident doors and waiting for response before entering resident rooms.	8/19/11
	Finding was confirmed by E30 (CNA) on 6/27/11 at 12 PM. E30 stated that the basin should have been emptied and given to the resident to put away prior to the lunch tray being set down.		Item # 3 Training will be provided by staff development and Infection Control Nurse to all nursing staff regarding proper cleaning of equipment and storage after each use.	8/19/11
	4a. On 6/29/11, E13 (CNA) delivered R42's lunch tray to her. E13 entered the room without knocking, washed her hands, went back into the hallway, retrieved and then delivered R42's lunch tray. 4b. On 7/1/11, E10 (CNA) and E15 (LPN) entered R42's room without knocking or waiting for permission to enter and E14 (CNA) knocked, but failed to wait for permission to enter R42's room three (3) separate times during an interview with	**Monitoring**	Nursing Supervisors, Infection Control Nurse, Nurse Managers and Charge Nurses will monitor compliance through daily observation. 2. Resident Care Practice Audit Tool will be utilized to identify any further concerns **(see Attachment B).** 3. Supervisory rounds will be conducted to ensure that staff are knocking on resident's room doors and waiting for response before entering room. 4. Resident Care Practice Tool will be forwarded to QA.	8/19/11 and ongoing

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F 241	Continued From page 4 R42 and a family member. Each time a staff member entered the room, they quickly turned and exited after seeing the surveyor. During an interview on 7/5/11 at 2 PM, R42 stated that staff often fail to knock before entering her room or they knock and do not wait to be acknowledged or given permission before entering.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to accommodate one resident's (R80) needs out of 32 sampled residents when R80 did not have a call bell placed within reach to call for assistance. Findings include: R80 was admitted on 2/1/11 with diagnoses including a history of multiple strokes with aphasia and organic brain syndrome. Review of R80's Significant change MDS (Minimum Data Set) assessment, dated 5/23/11, revealed that he was totally dependent and required 1 person assistance for activities of daily living, except for bed mobility and transfer which required 2 person	F 246	**Immediate Corrective Action** Upon notification of deficient practice, corrective action was immediately taken by placing R # 80 call bell within reach, on 07/05/11. Resident was able to activate call bell. **Identifying other residents having the potential to be affected** Nursing staff did a check of all residents to ensure that their call bells were accessible and within reach. **Systemic Response** All new residents admitted to EPBH will be assessed and their needs addressed. Nursing staff will continue the practice of every 2 hour rounds by Certified Nursing Assistants to assure that call bells are within reach of the resident. This will be documented on the residents' flow sheet each shift. In addition, all Licensed Nursing personnel will check placement of call bells when administering medication or performing treatments.	07/05/11 7/05/11 07/07/11 and ongoing

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F 246	Continued From page 5 assistance. R80's Functional Limitation in Range of Motion was coded "2" (impairment on both sides) for his upper and lower extremities. Review of R80's Physician Order Sheet, dated 6/17/11, revealed that R80 was to wear a splint on his right hand for 2 hours each shift and when asleep. During an interview on 7/5/11 at 8:31 AM, R80's call bell was observed clipped to the top of his pillow on his left side, hanging down to just above his left hand. R80 denied being able to use his call bell in this position and demonstrated that he was unable to reach it. During an interview on 7/5/11 at 9:13 AM, E17 (CNA) confirmed that R80's call bell was out of his reach, and stated that he never realized it was out of reach. E17 repositioned the call bell across R80's lap. R80 then demonstrated that he could use the call bell with his left hand. On 7/5/11 at 9:30 AM, E17 was overheard informing E18 (nurse) regarding informing other staff on all shifts in report about proper positioning of R80's call bell. On 7/6/11 at 7:55 AM, R80 was observed with his call bell across his lap in his hand.	F 246	**Monitoring** The C.N.A Flow Sheets will be checked off on a daily basis. Nursing Supervisors and Charge Nurses will perform random spot checks for the appropriate placement of resident's call bells. Any concerns will be addressed by utilizing the Resident Care Practice Audit Tool by DON or Designee. Results will be forwarded to QA quarterly.	08/19/11 and ongoing
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for R51 due to a soiled bathroom. The facility also failed to provide a sanitary and orderly environment as observed during the environmental tour of the facility on 6/30/11 and 7/1/11. Findings include: 1. On 6/28/11, R51 stated that at least twice a week the shared bathroom which she uses has feces on the floor. On 6/28/11 at 11:55 AM, an observation was made of R51's bathroom floor which revealed a small amount of feces on the floor. On 6/28/11 at 11:56 AM, E6 (LPN) came into the bathroom and confirmed the findings. E6 stated that she would have housekeeping come into the bathroom and clean it. Observations made during the environmental tour of the facility on 6/30/11 and 7/1/11 with E19 (Maintenance Director) and E2 (Hospital Administrator) revealed the following: 2. Observation of R17's oxygen concentrator on 7/1/11 at 8:50 AM revealed that the filter was missing while R17 was using the unit in the day room. The finding was confirmed with E20 (Nurse) on 7/1/11 and she subsequently switched the resident to an oxygen tank. E20 stated that the facility does not have procedures that address the cleaning/use of concentrators. Additionally on 7/1/11, heavy dust was observed on the oxygen concentrator filters belonging to R62, R70 and R79. In an interview with E20 on	F 253 Immediate Corrective Action	Item # 1 The feces found in the resident bathroom was cleaned up and the floor washed and sanitized. Item #2 Upon notification of deficient practices, oxygen concentrator filter was immediately replaced and cleaned. Upon notification, the hoyer lift was cleaned. Item #3 Two wobbly tables in day room were repaired immediately. Privacy Curtain in day room on Main 2 was replaced. Privacy curtains in the south wing shower room were washed and re-hung. Item # 4 Once notified, the harness and the wheelchair were cleaned. Green Chair was removed from floor and taken to Maintenance. Two red and the one brown chairs were cleaned by HSK Item # 5 Floor cleaning was addressed. Item # 6 Dusting of items listed was addressed by HSK staff and HSK Supervisor Item # 7 Dusting of items listed was addressed by HSK staff and HSK Supervisor	6/28/11 7/01/11 7/01/11 7/01/11 8/01/11 8/05/11 7/05/11 7/01/11 & 7/05/11 7/01/11 7/05/11 7/05/11

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F 253	Continued From page 7 7/1/11, she stated that she had to get an order from the physician to change filters in R62's oxygen concentrator. The clinical record lacked documentation that R62's filter was changed. Findings were confirmed with E2 (Hospital Administrator) on 7/1/11. 3. On 6/30/11 at 2:50 PM, two of four tables in the second floor day/dining room were observed to be unstable. On 7/1/11 at 8:45 AM, three (of three) tables in the third floor dining room were unstable. Additionally, on 6/30/11 at 2:50 PM, the privacy curtain in the second floor day/dining room, used to give residents privacy when weighing residents, was in disrepair. Privacy curtains were observed to be dirty in the south wing shower room on 7/1/11 at 7:25 AM. 4. On 6/30/11 at 2:50 PM, R81 was observed sitting in her wheelchair in the 2nd floor day/dining room and she had a chair harness on. The chair harness and the wheelchair were dirty. On 7/1/11, E2 (Hospital Administrator) stated that R81's harness and chair were cleaned. Dirty wheelchairs were observed for resident's use in rooms 206 and 303A. Additionally, on 7/1/11, an observation of the third floor day/dining room revealed one green chair upholstery in disrepair, two red chairs were dirty, and one brown chair was stained. 5. On 6/30/11 or 7/1/11, stained or dirty floors in resident rooms or bathrooms, were observed in	F 253	Item # 8 The base of the overbed table in room 222 was cleaned. Item # 9 Maintenance staff sanded doors on M2 & M3 west wing shower doors to address the immediate safety issue. Item # 10 The base of the overbed table in room 222 was cleaned. Upon notification, the soiled clothing items in the bathroom were removed. Item #11 Drains and sinks in rooms 212 & 220 were cleared. **Identifying other residents having the potential to be affected** Items # 1 & 10 A sweep was conducted of all residents' bathrooms for soiled and/or odors. Item # 2 Nursing staff checked all of the other oxygen concentrator filters. Items # 3 thru 9 Maintenance and Housekeeping and Nursing staff conducted sweeps of units to check and ensure tables, privacy curtains, wheelchairs, furniture, doors and residents' rooms were in satisfactory condition. Item #11 Maintenance staff completed check of all ice machines for proper drainage. **Systemic Response** Item # 1 Morning checks will be conducted by the custodial staff at the start and end of the shift to identify and address immediate	7/01/11 7/12/11 7/01/11 7/01/11 6/28/11 7/01/11 7/01/2011 thru 7/06/11 7/06/11 06/29/11 and ongoing

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F 253	Continued From page 8 rooms 201, 205/206, 212, 222, the 2nd floor west wing common shower room and the 2nd floor south wing shower room. Additionally, dirty resident bathroom sinks were observed in rooms 205, 215, 222 and 315. 6. On 6/30/11 or 7/1/11, dusty furniture (including dressers, tv cabinets, night stands, and book racks) were observed in resident rooms 201, 206, 220 and the 3rd floor day/dining room. 7. On 7/1/11, chipped doors were observed on the 2nd floor and the 3rd floor West wing resident common shower rooms. Interview with E19 (Maintenance director) on 7/1/11 revealed they were working on replacing chipped doors. 8. On 7/1/11, the base of an overbed table in room 222A and the platform/feet of a hoyer lift in the 2nd floor hallway were observed to be dirty. 9. On 7/1/11, a broken door cover in room 313 was observed. E19 (Maintenance Director) was observed calling maintenance staff to repair the cover right away. Additionally, the wall plate for the call bell system in resident room 323 was missing. Interview with E19 on 7/1/11 revealed the unit was a low voltage system and the plate did not get replaced after the room was repainted. 10. Observation of the resident bathroom for room 212 on 7/1/11 at 8:05 AM revealed an odor in the bathroom. Interview with R68 on 7/1/11 revealed the odor was always there. R68 revealed she did not use the bathroom; R15 was the only resident using the bathroom. E2 (Hospital Administrator) and E19	F 253	cleaning needs and document such on the daily checklist. Item #2 Procedure has been added for weekly cleaning / dusting of Oxygen Concentrators by Licensed Staff. Cleaning of Oxygen Concentrators will be scheduled weekly on the TAR (Treatment Administration Record). This will ensure that concentrators are clean weekly. Item #3 Maintenance staff assigned to nursing unit will complete periodic checks of every table for potential hazards. Maintenance will also respond to work orders within 24 hours for safety related concerns on the units. Item #4 C.N.A's will be assigned on the 11-7 shift to wipe down wheelchairs and lifts on the nursing units. Housekeeping staff will add checking of furniture and upholstery to their daily task list and address accordingly. Dept Head will also conduct weekly inspections. Items 5 & 6 Housekeeping staff will conduct checks at the start and end of the shift to identify and address immediate cleaning needs and document such on the daily checklist. Item # 7 Maintenance department contacted a company that sells protective corner molding to cover and/or repair chips in doors. Protective half sheet will be placed on lower outside of door for room 313. Continued on pages 9A & 9B	08/19/11 and ongoing 7/06/11 and ongoing 7/5/11 and ongoing 8/10/11 and ongoing 06/29/11 and ongoing 8/03/11

Systemic Response (continued)	Item #8 C.N.A's will be assigned on the 11-7 shift to wipe down hoyer lifts on the nursing units.	7/05/11 and ongoing
	Item #9 EPBH Facility Team will conduct grand rounds monthly to identify and address any environmental deficiencies.	7/06/11 and ongoing
	Item #10 All C.N.A's assigned to residents in rooms 212 and 211 will monitor and remove soiled clothing in the bathrooms each shift. They will also report any unusual odors to charge nurse for follow up cleaning with housekeeping.	7/05/11 and ongoing
	Item #11 Maintenance staff assigned to nursing unit will complete random testing of hand sinks for proper drainage. Maintenance will also respond to work orders.	7/06/11 and ongoing
Monitoring	Item #1 Housekeeping monitoring tools will be turned in to the QA administrator monthly.	08/19/11 and ongoing
	Item #2 Nursing developed an Equipment Monitoring Audit Tool for tracking cleaning/dusting of oxygen concentrators (see Attachments B and C). Nursing Quality Improvement committee will meet monthly and monitor compliance. Results will be forwarded to DON and QA Administrator.	

Continued on page 9B

Monitoring (continued)	Item #3 Facility Team's grand reports will be forwarded to QA Administrator and reviewed during quarterly QA committee meetings.	8/19/11 and ongoing
	Items #4, 5, 6, 7, 8, 9, 10 & 11 Housekeeping, Maintenance &/or Nursing monitoring tools will be turned in to the QA administrator monthly. Grand rounds will be completed monthly by facility team to identify any environmental deficiencies. Risk manager from DHCI will also complete quarterly rounds to identify same. Updates will be presented at Quarterly QA to maintain compliance	8/19/11 and ongoing

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F 253	Continued From page 9 (Maintenance Director) on 7/1/11 confirmed this finding. 11. On 7/1/11, resident hand sinks were observed to drain slowly in rooms 212 and 220.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility failed to develop a care plan for the use of psychotropic medications when R81 began to receive Seroquel (antipsychotic) and Clonazepam (benzodiazepine). Findings include:	F 279	**Immediate Corrective Action** Resident # 81 chart was reviewed and evaluated on 07/01/11. The physician evaluated the need for a psychotropic medication to treat behavioral symptoms, related to outburst crying episodes. The care plan was revised 07/01/11, to include the use of psychotropic medications. R#81's care plan was updated immediately upon notification. **Identifying other residents having the potential to be affected** All residents receiving psychotropic medications are at risk for this deficient practice. **Systemic Response** The care plan coordinator will be in-serviced regarding care planning for residents' using psychotropic medications (see Attachment D). All residents identified as using psychotropic medication will be reviewed at their quarterly IDCC meeting to ensure that a comprehensive care plan is been develop to address the need for a psychotropic medication. **Monitoring** Nursing Quality Improvement Nurse (NQI) will maintain file of residents who are receiving psychotropic medications and will monitor for care plan quarterly. Findings will be forwarded to QA.	07/01/11 07/01/11 7/5/11 and ongoing 8/19/11 and ongoing

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F 279	Continued From page 10 On 4/11/11, a physician's order was written for R81 to begin Seroquel as needed and Clonazepam every 8 hours. Review of R81's care plan revealed that the facility failed to develop a care plan for psychotropic drug use despite orders for Seroquel and Clonazepam on 4/11/11.	F 279		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that ordered treatments for contractures were provided as ordered for 1 (R68) out of 32 sampled stage 2 residents. Findings include: Observations revealed that the facility failed to apply the ordered long arm splint for 2 hours followed by application of a hand splint for 15 minutes after the long arm splint on 7/1/11. The treatment administration record (TAR) for 7/1/11 was blank (should be initialed if done). Review of R68's 5/11 TAR revealed for the entire month the evening shift had circled initials (indicating that treatment was not provided), but	F 318	**Immediate Corrective Action** The DON checked Resident #68's order for the long arm splint to treat contractures. DON addressed issue for properly documenting when residents refuse treatment. **Identifying other residents having the potential to be affected** All residents with adaptive devices have the potential to be affected by the cited deficient practices. **Systemic Response** All Licensed Staff will receive refresher training by the Staff Development department regarding treatment orders and the need to make follow up when resident refuses treatment. Refresher training for all nursing Licensed Staff regarding reporting and documenting.	7/01/11 8/19/11 and ongoing

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F 318	Continued From page 11 failed to document why the splints were not applied. Review of nurse's notes for May 2011 also lacked documentation of why the splints were not applied. Interview with E31 (RN), who at times functions as the evening treatment nurse, stated on 7/1/11 at 5 PM, that some of the circled initials on the 5/11 TAR were hers and they were circled because the resident refused the splints. She confirmed that she did not document anything on the back of the 5/11 MAR. Review of the record also lacked evidence that staff did not notify occupational therapy regarding R68's not following the plan of care for the splint wearing schedule.	F 318	**Monitoring** A monthly random audit of 20% of the Treatment Administration Record regarding documentation and reporting of resident refusals will be conducted by Nursing Supervisors or designee. Results will be reviewed at the monthly NQI Committee meetings x 12 months or until substantial compliance is achieve.	8/19/11 and ongoing
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to maintain an environment free from accident hazards as evidenced by unattended and unlocked personal products/supplies or chemicals. Findings include: During the environmental tour of the facility with	F 323	**Immediate Corrective Action** Once the facility was notified of the deficient practice, corrective action was immediately taken by removing all hazardous and unattended personal products and supplies from the unsecured areas (shower room) and placed into the secured areas (night stand drawer). **Identifying other residents having the potential to be affected** Once the facility was notified of the deficient practice, corrective action was immediately taken by removing all hazardous and unattended personal products and supplies from the unsecured areas (shower room) and placed into the secured areas (night stand drawer).	7/05/2011 7/05/2011

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F 323	Continued From page 12 E2 (Hospital administrator) and E19 (Maintenance Director), personal supplies/chemicals such as lotions, shampoos, body wash, perineal care bottles, mouthwash, and/or deodorants were observed stored on the 2nd floor south wing shower room, in room 217 supply closet, on two clean linen carts stored on the 3rd floor hallway, and on the third floor south wing common shower room. Interview with E21 (Nursing Supervisor, RN) on 7/1/11 revealed that the personal supplies or chemicals found were not supposed to be stored in these areas and they needed to be locked. E2 (Hospital Administrator) on 7/1/11 confirmed agreement that these items should be locked and stated it was their facility policy. The policy was requested, but not received.	F 323	**Systemic Response** Training will be provided by Staff Development to ensure residents' personal items are secured in night stand drawer. Staff will be reminded to place their personal items on their person or in break room. Random rounds will by conducted on all shifts by nursing supervisors and charge nurses to ensure compliance. **Monitoring** Resident Care Audit will be utilized and any findings will be reported to the Director of Nursing (DON) / Assistant Director of Nursing (ADON) or designee for corrective action and the results will be forwarded to QA.	8/19/11 and ongoing 8/19/11 and ongoing
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on resident interviews and test tray results, it was determined that the facility failed to provide food that was palatable, attractive and served at the proper temperature. Findings include: 1. On 6/30/11 at 11:48 AM a test tray was	F 364	**Immediate Corrective Action** Items # 1,2,4,5,6 - Hot Food Temperatures: Food Service Director immediately addressed the food delivery system. He also surveyed the nursing units to determined residents' needs. Item # 3 - Cold Food/Drink temperatures: Immediately upon discovery, the milk identified was discarded. A check of the refrigeration system detected it was not operating properly and a work order was submitted. An alternative refrigerator was used until refrigerator was serviced. Maintenance contacted contractor ERM to service the refrigerators identified. Service was completed on each refrigerator on two separate dates.	6/30/2011 6/30/2011

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F 364	Continued From page 13 sampled on the second floor for temperature and palatability. The test tray was delivered on the second meal cart and after all residents received and began eating, the test tray was sampled for temperatures and taste. The food temperatures were as follows: potatoes=126.3 degrees Fahrenheit (F), ham=119.3 F; coffee=154.2 F; iced tea=53.7 F. The food was determined to be unpalatable. 2. On 6/30/11 at 12:10 PM, a test tray was sampled on the third floor for temperature and palatability. The test tray was delivered on the third meal cart and after all residents received their trays and began eating, the test tray was sampled for temperature and taste.The pureed test tray had sweet potatoes, ham and string beans. The food temperatures were as follows: sweet potatoes = 156 degrees Fahrenheit (F), ham = 126 F; string beans = 123 F; iced tea = 54.8 F. The food was not palatable, the sweet potatoes were bitter, the ham tasted bad and was lukewarm, the green beans were bland and lukewarm and the iced tea was too warm. 3. Observation of food temperatures in the kitchen steam table area on 6/30/11 at 11:15 AM revealed the temperature of three milk containers to be above 41 degrees Fahrenheit (F) while milk was placed on resident trays for R10, R19, R14, R44, R47, and R55. The 8-oz regular milk inside the milk refrigerator was tested at 47.2 F; two 4-oz skim milk cartoons inside the reach-in refrigerator were tested at 50F and 52.9 F respectively (60 F with facility thermometer).	F 364	**Identifying other residents having the potential to be affected** Items # 1-6 All residents are potentially affected when food/beverages are not maintained at the proper temperatures. **Systemic Response** Dietary Department was re-trained on maintaining proper food/drink temperatures through serving line and storing process. The reach-in refrigerators were placed on a quarterly service/cleaning contract. Temperatures were lowered in the refrigerator from 40 to 36 degrees to ensure milk does not reach above 40 degrees prior to delivering to residents for consumption. Item # 3 Palatability: Cooks trained on using standardized recipes. Seasonings will be used appropriately as diet permits. Meat selections will be checked for quality. Food Service Director will maintain record of any feedback to food suppliers/vendors related to food quality issues. **Monitoring** Food Service supervisor or designee will monitor and check serving line to ensure staff follows establishment guidelines. Cook Supervisor will monitor daily temperature logs and randomly take temperatures of food during the plating and serving process.	7/1/11 7/22/11 7/22/11 8/03/11 8/08/11 and ongoing 8/03/11 and ongoing for all items

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F 364	Continued From page 14 The surveyor brought the concern to the attention of E22 (Food Services Director). On 6/30/11, while the milk was still being placed on the trays, the surveyor again stated that the milk was not at the proper temperature. E22 was observed asking dietary staff if they stopped serving the milk. The staff in turn stated that she stopped serving the 8-oz containers, yet was still serving the 4 oz milk containers. E22 requested his staff to get milk from the walk-in refrigerator which was at the proper temperature. 4. During an interview on 6/29/11at 12:05 PM, R42 stated that her food is often served cold. She stated that the facility bought new dishes, but it does not always solve the problem. The results of the test trays done on 6/30/11 at 12:30PM confirmed findings of unpalatable food which was not served hot enough. 5. During an interview on 6/29/11at 8:18 AM, R80 indicated that hot foods are not served hot enough and cold foods are not served cold enough. The results of the test trays done on 6/30/11 at 12:30PM confirmed findings that food is not served at the correct temperatures. 6. During an interview on 6/29/11at 9:09 AM, R54 stated that most of the time his food is not served hot enough. The results of the test trays done on 6/30/11 at 12:30 PM confirmed findings of unpalatable food which was not served hot enough.	F 364	Dietician Assistant will test food trays for palatability and proper temperatures. Trays will be tested 3 times a week for all three meals served. Residents will continue to be surveyed quarterly on their likes, dislikes, and changes will be made to the menu selections. Monthly Resident Council meetings will also be used to monitor overall satisfaction. Dietary monitoring tools will be forwarded to the QA administrator monthly. DHCI risk manager completes quarterly visits and will be completing a random sample of temperatures and providing feedback on observations. Updates will be presented at Quarterly QA to maintain compliance.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 15 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based upon observation and interview, it was determined that the facility failed to prepare, distribute and serve food to the residents under sanitary conditions. Findings include: 1. Observations of the ice machine in the kitchen on 6/27/11 and 7/7/11 revealed that the drain tubing was inserted into the grate of the floor drain. E22 (Food Service Director) confirmed the absence of an air gap. 2. Sanitizer was not detected in cleaning buckets on 6/27/11 at approximately 10:45 AM. 3. Review of facility Food Employee health form documentation revealed that health forms were missing for one (1) of four sampled dietary staff (E25). The health forms are used to screen food employees' health at the time of hire and to alert the facility if the employee has certain foodborne illness(es) that would prevent them from working with food. E25 was hired on 02/02/09. Interview with E2 (Hospital Administrator) on 7/6/11 revealed that the health forms was not completed for E25 upon hire.	F 371	**Immediate Corrective Action** Items #1 & 4 Maintenance staff corrected the improper drain pipes and air gaps on the ice machines in the kitchens and nursing units. Items #2 &5 Dietary immediately discontinued the use of chlorine as a sanitizer for the three compartment sink and sanitation buckets/pails. Quaternary Sanitizer is now used in the three compartment sink and sanitizer buckets. Staff training completed on new sanitizer product to ensure proper concentration is used for cleaning/sanitizing kitchen prep areas and equipments. Written instructions and log to document daily testing added. Item #3 Food Service Director reviewed the missing record for employee E25. This employee has been out on extended leave for approximately three as a result of a personal tragedy. This will be addressed before E25's return to work. **Identifying other residents having the potential to be affected** Maintenance staff checked all of the ice machines to ensure proper air gag in drainage lines. **Systemic Response** Items #1 & 4 Foreman will monitor future drain pipe work to ensure proper air gap is maintained after completion of project. Maintenance Foreman will complete periodic rounds to check ice machine drains	7/08/2011 6/30/11 7/08/2011 8/10/2011 and ongoing 8/10/11 and ongoing

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F 371	Continued From page 16 4. Observations of the ice machine in the kitchen on 7/7/11 revealed that the drain pipe for the ice machine was a red flexible hose inserted into a grated drain pipe on the floor. An air gap as required by the Delaware 2011 food code was not observed. Interview with E22 (Food Services Director) on 7/7/11 confirmed that an air gap was missing from the ice machine. E22 had no access to the drain pipe. Additionally, observations of the ice machine drain line in the second and third floor kitchenettes (or nourishment rooms) on 7/1/11 revealed a flexible hose drain line from the ice machine connected into an open drain pipe on the floor. The 2011 Delaware Food code requires that a gap be observed from drains on equipment storing or handling food such as ice. 5. On 6/30/11 at 10:30 AM, the sanitizer concentration of four pails were tested using a test strip. The concentration of the sanitizer on two (of the four) pails were detected at above 300 PPM. Additionally, the concentration of a chlorine sanitizer station (cup of sanitizer), used to sanitize the thermometer between testing food temperatures at the steam table, was tested and measured approximately 300 PPM. Per Delaware 2011 food code, the chlorine concentration cannot be higher than 100PPM under a certain temperature condition. This also is a hazard as chlorine is very corrosive and can burn. Interview with E22 (Food Services Director) on 7/7/11, and kitchen procedures review, revealed that the concentration of the chlorine was supposed to be maintained at 50 PPM. E22 on	F 371	Items 2 & 5 Per the surveyors' suggestion, Dietary staff will fill cleaning buckets and thermometer holder each shift from the three compartment sink that has the proper concentration of sanitizer. Sanitation levels will be monitored 3 times a day. Improper levels will be adjusted as needed New employee training and Semi annual training will be completed on food safety practices which will include sanitation process. Any new product purchased will be reviewed with staff if usage levels change from previously ordered product. Cook Supervisor will monitor the log and test the sanitizer buckets/thermometer holder daily. The Sr. Food Service Workers will also monitor the completion of the log. Any deficient practices will be reported directly to Food Service Director, who will record the incident and follow up in an appropriate manner. Food Service Director to complete periodic sampling and observe staff testing process. Item #3 Food Service Director will ensure employee E25's health record is updated before returning to work. Continued on page 17A	7/01/2011 and ongoing 8/12/2011

Monitoring

Items #1 & 4

Maintenance monitoring tools will be turned in to the QA administrator monthly. Grand rounds are completed monthly by a facility team to identify any environmental deficiencies. DHCI risk manager completes quarterly rounds to identify same. Updates will be presented at Quarterly QA to maintain compliance — 8/19/11 and ongoing

Items #2 & 5

Dietary monitoring tools will be forwarded to the QA administrator monthly. DHCI risk manager completes quarterly visits and will be completing a random sample of sanitation levels. Updates will be presented at Quarterly QA to maintain compliance. — 8/12/2011 and ongoing

Item #3

A signed health forms for all employees hired will be sent to QA administrator to ensure compliance. — 8/12/2011 and ongoing

F253	**Page 9, #9 Part 2**	
Immediate Corrective Action	Maintenance replaced call bell plate in Room 323.	7/5/11
Identifying other residents having the potential to be affected	Every call bell plate in the facility was checked, no further action was required.	7/1/2011
Systemic Response	Maintenance Foreman or designee will monitor contractors and project completions to ensure no potential hazards remain.	7/1/11-ongoing
	Mechanic assigned to floor will complete a periodic check of each room for damaged or missing call bell plates. Repairs to be made immediately upon discovery,	7/6/11
	All staff identifying damage to a call bell plate will complete a work order upon discovery. Action will be taken to repair within 24 hours of receipt.	
	Maintenance Foreman will complete periodic rounds to check call bell plates.	
Monitoring	Maintenance monitoring tools will be turned in to the QA administrator monthly. Grand rounds are completed monthly by a facility team to identify any environmental deficiencies. DHCI risk manager completes quarterly rounds to identify same. Updates will be presented at Quarterly QA to maintain compliance	

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F 371	Continued From page 17 7/7/11 stated that the facility switched back to the quaternary solution as they could not properly control the chlorine sanitizer concentration at the correct concentration.	F 371 **Immediate Corrective Action**	The Food Service Director had food service worker empty trash cans and secured lids to trash cans. Staff in-serviced on the proper procedure on trash can lids.	6/27/2011
F 372 SS=B	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to dispose of garbage and refuse properly. Findings include: On 6/27/11 at 10 AM, observations of an area across from the handwashing sink revealed that two waste receptacles were stored without lids. E22 (Food Service Director) confirmed the finding.	F 372 **Identifying other residents having the potential to be affected**	A sweep of all trash cans was completed and lids placed on each can. Lids on cans while not in use maintained daily. F 372 continued on page 18A	6/27/2011
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	**Immediate Corrective Action** F 428 **Identifying other residents having the potential to be affected**	Once the facility was notified of the deficient practice, corrective action was taken by completing clinical pharmacy review for R # 59 for the months of May and June. **(See attachment E)** All residents have the potential to be affected by the deficient practice. A sweep of all other residents' charts was done to verify that pharmacy chart reviews were completed.	7/05/11 7/05/2011

Systemic Response	Staff has been in-serviced on the usage and importance of trash can lids being used properly. Staff will continue to empty trash cans at the end of each shift Cook Supervisor will monitor trash cans to ensure lids are in place between usages. Sr. Food Service Workers will report any deficiencies to Cook Supervisor. Any deficient practices will be reported directly to Food Service Director, who will record the incident and intervene as appropriate.	6/28/11 and ongoing
Monitoring	Grand rounds are completed monthly by a facility team to identify any environmental deficiencies. Placement of trash can lids will be added to items observed. DHCI risk manager completes quarterly rounds to identify same. Updates will be presented at Quarterly QA to maintain compliance.	8/19/2011 and ongoing

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F 428	Continued From page 18 by: Based on record review and interview, it was determined that the facility failed to have monthly drug regimen reviews completed by a licensed pharmacist for 1 (R59) out of 32 sampled stage 2 residents. Findings include: R59 was admitted to the facility on 4/6/11. A monthly drug regimen review was done on 4/19/11, however, as of 7/1/11, there were no monthly drug regimen reviews done in May or June 2011. Findings were discussed with E20 (LPN) on 7/1/11. E20 called the pharmacy and advised the surveyor that the pharmacy would try to get hold of the pharmacist assigned to the facility. As of 7/11/11, no additional information was received by the facility.	F 428	**Systemic Response** The newly assigned Pharmacist was not aware of facility protocol for requesting residents' medical records. R #59's record was with the attending physician for a renewal that was due. Because R #59's chart was not immediately available, the pharmacist did not complete the monthly drug review. Pharmacy was oriented to facility protocol on 08/02/11.	8/02/2011 and ongoing
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	**Monitoring** Pharmacy will submit a monthly report to the Director of Nursing regarding completed monthly drug regiment and will forward to QA. This report will be review at monthly NQI meeting to ensure that reports are completed in a timely manner X 12 months. Any discrepancies found will be reported to the pharmacy director for corrective action and results will be forwarded to QA.	8/02/2011 and ongoing

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	085022	A. BUILDING _____ B. WING _____	C 07/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMILY P. BISSELL HOSPITAL	3000 NEWPORT GAP PIKE WILMINGTON, DE 19808

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F 441	Continued From page 19 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection related to the improper hand washing technique of staff providing care for 3 out of 32 Stage 2 sampled residents. Findings include: The facility Handwashing policy (100.10) and procedure, dated 5/23/11, was reviewed and included a hand hygiene technique, " ...6. Leaving water running, obtain paper towel from dispenser and dry hands thoroughly. 7. Using a new paper	F 441	**Immediate Corrective Action** Item #1, 2 & 3 The Director of Nursing and Infection Control Nurse individually addressed and reviewed proper handwashing techniques with employees (E9, E7 & E8). **Identifying other residents having the potential to be affected** All residents are risk for this deficient practice. All staff is to follow the Hand Hygiene Policy. **(See Attachment F).** **Systemic Response** All nursing staff will be in-serviced on Hand Hygiene Policy, with emphasis on proper hand washing. The Infection Control Nurse and Nursing Supervisors will continue to stress the importance of hand washing. The Resident Care Audit Tool will be used to document rounds. **(See attachment A).** **Monitoring** Results of the Resident Care Audit Tool will be reviewed monthly at Nursing QI Committee meeting and will be forwarded to QA.	6/27, 6/28 & 6/30/2011 8/19/2011 and ongoing 8/19/2011 and ongoing

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F 441	Continued From page 20 towel, turn off the faucet. DO NOT touch the faucet handles once your hands are clean, to prevent recontamination of hands... Indications for hand washing and hand antisepsis - K. When hands are obviously soiled or following housekeeping tasks..." 1. On 6/27/11 at 12:23 PM, an observation was made of E9 (CNA) picking up R67's meal ticket from the floor in the third floor dining room with her bare hands which were in contact with the floor. E9 then proceeded to get a pair of gloves, went to R67 and picked up the spoon and fed a spoonful of orange sherbet to R67. She also offered the resident chocolate milk. When R67 did not want any more lunch, E9 removed the tray. At 12:28 PM, E9 left the dining room and in an interview E9 confirmed the observation. E9 stated that she should have washed her hands after picking up the meal ticket from the floor and prior to feeding R67. 2.On 6/28/11 at 10:35 AM an observation was made of E7 (LPN) washing her hands at R76's sink prior to providing care. E7 shut the faucet off with the wet paper towel she used to dry her hands. E7 then re washed her hands, used a separate paper towel to shut off the faucet but then she wiped her hands with this same paper towel, recontaminating her hands. On 6/28/11 at 10:40 AM in an interview with E7, she confirmed the findings. 3.On 6/30/11 at 9:10 AM during the Medication Pass observation with E8 (LPN) she washed her hands after applying a Lidoderm patch to R47. E8 was observed shutting off the faucet with the wet paper towel that she had used to dry her hands.	F 441		

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F 441	Continued From page 21 On 6/30/11 at 9:12 AM in an interview with E8, she confirmed the findings.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to have a functional call bell system in place for 1 (R59) out of 32 sampled stage 2 residents. Despite notification of staff and placement of a work order, the call bell remained non-functional for 24 hours before being replaced. Findings include: On 6/27/11 at 2:48 PM, R59's call bell was observed hanging from the wall and it was non-functional. The call bell was given to R59 and she easily demonstrated how to use her call bell. On 6/27/11 at approximately 2:55 PM, E12 (CNA) confirmed that R59's call bell did not work and she stated that she would put in a work order. On 6/28/11 at 9:18 AM, R59's call bell was within reach, but still not functional. On 6/28/11 at 2:16 PM, R59's call bell continued to be non-functional. E20 (LPN) confirmed findings. E20 checked and confirmed that a work order was put in immediately on 6/27/11 by E12,	F 463	**Immediate Corrective Action** Call bell was repaired. **Identifying other residents having the potential to be affected** Sweep of call bells in all resident areas was completed. No other call bells were found inoperable. Research was done to identify the reason for the work order not to be completed after request was submitted. Problem identified. **Systemic Response** All staff to be trained on identifying priority work orders and action required in what time frames. Foreman will monitor high priority work order assignments daily. **Monitoring** Maintenance monitoring tools will be turned in to the QA administrator monthly. Grand rounds are completed monthly by a facility team to identify any environmental	6/28/2011 6/29/2011 7/01/2011 8/05/11 and ongoing 8/19/2011 and ongoing

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F 463	Continued From page 22 however, the work order inadvertently stated that R59's call bell worked instead of saying that it did not work. On 6/28/11 at 2: 56 PM, staff were observed in R59's room. The call bell was replaced and found to be in working order. Staff stated that they did not know about R59's call bell "until a few minutes ago... have 10 brand new call bells." When maintenance staff were asked how soon they normally respond to a non-functional call bell, they stated, "immediately." Findings were discussed with E3 (Director of Nursing) on 6/28/11.	F 463		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that clinical records were accurate for one (R68) of 32 sampled residents. Findings include:	F 514	**Immediate Corrective Action** Resident #68 was not negatively impacted as a result of this deficient practice. All laboratory services were provided to the right resident in a timely and efficient manner. Unfortunately, the laboratory reports were filed under the wrong name. Both residents R #68 and R #78 have the same first and last names. Once the facility was notified of the deficient practice, corrective action was taken by notifying the lab provider to verify names associated with right birth dates prior to submitting reports. **Identifying other residents having the potential to be affected** Other records were reviewed within the facility, no residents were found to have the same name. **Systemic Response** A review of both charts on 07/01/11 determined that all medical records were within the correct chart.	7/01/2011 7/01/2011

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F 514	Continued From page 23 Review of R68's laboratory results revealed that from 1/11 through 6/11 (on 6 occasions) this resident's date of birth was incorrectly listed. The date of birth listed on R68's laboratory results were another resident's (R78-same first and last name, but with a middle initial) residing on another floor. During an interview with E3 (DON) on 7/1/11, E3 acknowledged that R68's date of birth was incorrect on the laboratory results.	F 514	Upon receipt of Laboratory results from the provider, Operation Support Specialist (OSS) or Charge Nurse will check both residents to ensure accuracy of names associated with birth dates and results prior to filing results into the medical records. Name alert tags will be placed on outside of charts for these two residents to remind staff to verify identity. **Monitoring** The Charge Nurse will verify all lab reports are filed in the correct chart, especially for the two residents with the same first and last names.	8/19/2011 and ongoing 8/19/2011 and ongoing
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on review of staff in-service documentation and staff interviews, it was determined that the facility failed to ensure that four (4) of fourteen (14) sampled staff (E26, E27, E28, and E29) were trained in emergency procedures when they began work at the facility or periodically thereafter. Findings include: Staff interviews on 6/30/11 and 7/1/11 were conducted to determine if staff had emergency preparedness training and were ready to handle emergency situations at the facility. E29 (CNA) working the third shift on the 2nd floor on 7/1/11 at 6:50 AM revealed that she had not had training	F 518	**Immediate Corrective Action** The four staff identified in the survey (E25, E26, E27 and E28) will receive training. **Identifying other residents having the potential to be affected** A review of all employees training records was completed and those needing the annual training were identified. **Systemic Response** Security and Training Department staff will provide Fire & Safety Training, Missing Person Training, and Weather & Disaster Training to all staff. The training will be placed on the training schedule for annual implementation. **Monitoring** Hospital Administrator to receive training attendance sheets to ensure all staff has attended. This training will reoccur annually.	8/19/2011 7/08/2011 8/19/2011 8/19/2011 and ongoing

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F 518	Continued From page 24 on missing persons, weather, and other related emergencies since being hired. Review of facility in-service records for four employees (E25, E26, E27 and E28) revealed their emergency preparedness in-service records were missing. Documentation of in-service training to validate which staff had emergency training out of the fourteen was not available for four staff as shown below. 1. E25 (Dietary staff) hired on 2/2/09 had no emergency preparedness training since hire. 2. E26 (Activity staff) hired on 6/15/09 had no emergency preparedness training since 7/1/09. 3. E27 (Laundry staff) hired on 7/1/09 had no emergency preparedness training since 8/5/09. 4. E28 (Nurse, RN I) hired on 6/13/11 had no emergency preparedness training upon hire. Interview with E2 (Hospital Director) revealed that E28 was scheduled to attend emergency preparedness training on 7/6/11. On 7/5/11, E2 and E19 (Maintenance Director) confirmed these findings during an interview.	F 518	**Immediate Corrective Action** The four staff identified in the survey (E25, E26, E27 and E28) will receive training. **Identifying other residents having the potential to be affected** A review of all employees training records was completed and those needing the annual training were identified. **Systemic Response** Security and Training Department staff will provide Fire & Safety Training, Missing Person Training, and Weather & Disaster Training to all staff. The training will be placed on the training schedule for annual implementation. **Monitoring** Hospital Administrator to receive training attendance sheets to ensure all staff has attended. This training will reoccur annually.	8/19/11 7/8/11 8/19/11

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Emily P. Bissell Hospital

DATE SURVEY COMPLETED: July 7, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility from June 27, 2011 through July 7, 2011. The deficiencies contained in this report are based on observations, interviews, review of clinical records as well as other documentation as indicated. The facility census on the first day of the survey was seventy eight (78). The stage 2 survey sample totaled 32.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 7/7/11, F241, F246, F253, F279, F318, F323, F364, F371, F428, F441, F463, F514 and F518.	3201.1.2 Cross referenced CMS 2567 Tags # F241, F246, F253, F279, F318, F323, F364, F371, F428, F441, F463, F514 & F518.

Provider's Signature _____ Title Director Date 8/6/11

DELAWARE HEALTH
AND SOCIAL SERVICES
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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.0	Services to Residents	
3201.6.3	Nursing Administration	
3201.6.3.8	The resident has the right to be free to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This requirement is not met as evidenced by: Cross refer to CMS 2567-L survey date completed 7/7/11, F221.	3201.6.3.8 Cross referenced CMS 2567 Tag # F221
3201.7.5	Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code. 2-201.11 Responsibility of Permit Holder, Person in Charge, and Conditional Employees. (A) The permit holder shall require food employees and conditional employees to report to the person in charge information about their health and activities as they relate to diseases that are transmissible through food. A food employee or conditional employee shall report the information in a manner that allows the person in charge to reduce the risk of foodborne disease transmission, including providing necessary additional information, such as the date of onset of symptoms and an illness, or of a diagnosis without symptoms, if the food employee or conditional employee: reportable symptoms (1) Has any of the following symptoms:	

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	(a) Vomiting, (b) Diarrhea, (c) Jaundice, (d) Sore throat with fever, or (e) A lesion containing pus such as a boil or infected wound that is open or draining and is: (i) On the hands or wrists, *unless an impermeable cover such as a finger cot or stall protects the lesion and a SINGLE-USE glove is worn over the impermeable cover,* (ii) On exposed portions of the arms, *unless the lesion is protected by an impermeable cover,* or (iii) On other parts of the body, *unless the lesion is covered by a dry, durable, tight-fitting bandage; reportable diagnosis* (2) Has an illness diagnosed by a health practitioner due to: (a) Norovirus, (b) Hepatitis A virus, (c) *Shigella* spp., P (d) Enterohemorrhagic or Shiga Toxin-producing Escherichia Coli, or (e) *Salmonella* Typhi; *reportable past illness* (3) Had a previous illness, diagnosed by a health practitioner, within the past 3 months due to *Salmonella* Typhi, without having received antibiotic therapy, as determined by a health practitioner; reportable history of exposure (4) Has been exposed to, or is the suspected source of, a confirmed disease outbreak, because the food employee or conditional employee consumed or prepared food implicated in the outbreak, or consumed food at an event prepared by a person who is infected or ill with: (a) Norovirus within the past 48 hours	

AME OF FACILITY: Emily P. Bissell Hospital

DATE SURVEY COMPLETED: July 7, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	of the last exposure, **(b) Enterohemorrhagic or Shiga Toxin-producing Escherichia Coli, *or Shigella* spp. within the past 3 days of the last exposure,** **(c) *Salmonella* Typhi within the past 14 days of the last exposure, or** **(d) Hepatitis A virus within the past 30 days of the last exposure; or** ***Reportable history of exposure*** **(5) Has been exposed by attending or working in a setting where there is a confirmed disease outbreak, or living in the same household as, and has knowledge about, an individual who works or attends a setting where there is a confirmed.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 7/7/11, F371, Example #3. **3-304.14 Wiping Cloths, Use Limitation.** **(B) Cloths in-use for wiping counters and other equipment surfaces shall be:** **(1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114** **4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness.** **A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under ¶ 4-703.11(C) shall meet the criteria specified under § 7-204.11 Sanitizers, Criteria, shall be used in accordance with the EPA registered label use instructions, and shall be used as follows P:**	3201.7.5 Cross referenced CMS 2567-L Tag # F371, Example #3.

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED

(A) A chlorine solution shall have a minimum temperature based on the concentration and PH of the solution as listed in the following chart;

Concentration Range	Minimum Temperature	
MG/L	PH 10 or less °C (°F)	PH 8 or less °C (°F)
25 – 49	49 (120)	49 (120)
50 – 99	38 (100)	24 (75)
100	13 (55)	13 (55)

This requirement is not met as evidenced by:

Cross refer to CMS 2567-L survey date completed 7/7/11, F371, Example #2 and #5.

3201.7.5 Cross referenced CMS 2567-L Tag # F371, Examples #2 and #5.

5-402.11 Backflow Prevention.

(A) Except as specified in ¶¶ (B), (C), and (D) of this section, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed.
5-204.12 Backflow Prevention Device, Location.

This requirement is not met as evidenced by:

A backflow prevention device shall be located so that it may be serviced and maintained.

Cross refer to the CMS 2567-L survey report date completed 7/7/11, F371, Example #1 and #4.

5-402.11 Cross referenced CMS 2567-L Tag # F371, Examples #1 and #4.

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	5-501.113 Covering Receptacles. Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered: **(A) Inside the food establishment if the receptacles and units:** **(1) Contain food residue and are not in continuous use; or** **(2) After they are filled; and** **(B) With tight-fitting lids or doors if kept outside the food establishment.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 7/7/11, F372.	**5-501.113** Cross referenced CMS 2567-L Tag # F372:
16 Del. C., Chapter 11, Subchapter II, §1121	**Patient's Rights** **(1) Every patient and resident shall have the right and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 7/7/11, F241.	**16 Del. C., Chapter 11, Subchapter II, §1121** Cross referenced CMS 2567-L Tag # F241.